SARASOTA RETINA INSTITUTE SRI

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Suite 200
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(941) 921-5335
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Additional Offices:
Lakewood Ranch
Venice

Dear _____:

Welcome to **Sarasota Retina Institute**. This letter will confirm your appointment with **Thomas C. Spoor, M.D**. on_____ at_____ in our _____office.

Please complete the enclosed forms and give them to the front desk receptionist when you arrive for your first appointment. The enclosed patient HIPAA Compliance Notification form also needs to be signed and returned. Bring your insurance cards with you so we may copy them for our record

Plan to spend approximately two to four hours with us, as a very extensive examination will be performed. Your eyes will be dilated; therefore, we recommend you bring someone who can drive you home. **Please arrive a minimum of 15 minutes before your scheduled appointment.**

Please ask your referring doctor and any other doctors you have seen to send us either a summary or a copy of your records. If you have had skull x-rays, CT scans, arteriograms, or MRI's in the past three years, please bring the films with you, not just the report. Do not mail them as they can be lost or delayed. Likewise, if you have a problem with either unequal pupils, deviation of the eyes, or drooping eyelids, please bring old photographs with you. The pictures can be baby, family, wedding or ID photos.

You should bring any eye glasses you currently wear, as well as any additional information or hospital records you may have. You may require additional testing during the day, and a complete report of your examination will be sent to your doctor.

FINANCIAL POLICY

We participate with Medicare and several major insurance companies. Payment is due at the time of service, if we do not have a contract with your insurance company or you have a co-pay. Our insurance department will call and verify your insurance and any deductibles and co-pays the day of your first visit. If we provide a service that is considered non-covered by your insurance, payment is due at the time of the service. For your convenience, we accept MasterCard, Visa and Discover and American Express.

ATTENTION MEDICARE PATIENTS: If you have a Medicare Managed Plan, you must let us know the name and phone number of your primary care physician and the name of your managed care plan. We must have authorization from your primary care physician prior to your visit.

ATTENTION MANAGED CARE OR HMO PATIENTS: If you have an insurance plan that requires prior authorization, we must have the name and phone number of your primary care physician. **We must have authorization from your primary care physician prior to your visit. It is your responsibility to obtain this authorization.**

**If your condition is due to an accident, you must notify our insurance department prior to your visit. The phone number is 941-927-2050.

Our staff may call to verify appointments by leaving a message, if necessary. If you miss an appointment, you may be informed by mail to reschedule the appointment.

If you have any questions regarding our financial policy, please contact one of our Patient Account Representatives at 941-927-2050 in our Billing and Insurance office.

Sincerely

Front Office Staff
941-921-5335

SARASOTA RETINA INSTITUTE PATIENT INFORMATION

Please verify that all of the information below is accurate, and make any changes or additions if necessary.

DATE:_____ PATIENT ID:_____REFERRING PHYSICIAN:_____

PATIENT NAME:_____PATIENT'S SOC. SEC. #:_____

ADDRESS:_____

CITY:_____ STATE:_____ZIP:_____

DATE OF BIRTH:_____ SEX: _____RACE:_____ETHNICITY: O Hispanic O Not Hispanic

LOCAL PHONE NUMBER:_____CELL PHONE NUMBER:_____

Email Address: _____

EMPLOYER:_____ WORK PHONE NUMBER:_____

YEAR ROUND RESIDENT? YES / NO. IF NO, MONTHS SPENT HERE: FROM_____TO_____

OUT OF STATE ADDRESS:
(STREET) _____

CITY: _____STATE:_____ZIP CODE_____ TELEPHONE NUMBER: _____

SPOUSE/PARENT/GUARDIAN:_____

PERSON RESPONSIBLE FOR
BILL:_____RELATIONSHIP:_____

THE FOLLOWING PERSON IS AUTHORIZED TO DISCUSS MY MEDICAL AND/OR FINANCIAL ISSUES:

NAME:_____PHONE:_____RELATIONSHIP_____

I HAVE REVIEWED ALL INFORMATION AND THE INFORMATION I HAVE PROVIDED IS CORRECT AND CURRENT TO THE BEST OF MY KNOWLEDGE.

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION, OR ITS INTERMEDIARIES, OR CARRIERS, OR TO THE BILLING AGENT OF THE PHYSICIAN, OR SUPPLIER, ANY INFORMATION NEEDED FOR THIS, OR RELATED MEDICARE CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF, OR TO THE PARTY WHO ACCEPTS ASSIGNMENT.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE. IN CASE OF PAST DUE PAYMENT, NON-PAYMENT, OR IRREGULAR PARTIAL PAYMENTS, I MAY BE CHARGED COLLECTION AND/OR LEGAL FEES AND/OR ½% INTEREST PER MONTH

PATIENT SIGNATURE: _____ DATE: _____
(OR PARENT OR GUARDIAN, IF MINOR, OR UNDER GUARDIANSHIP)

INSURANCE INFORMATION

PRIMARY INSURANCE

NAME AS APPEARS ON CARD:_____

INSURANCE COMPANY NAME & ADDRESS:_____

PHONE NUMBER:_____POLICY#:_____GROUP #:_____

EFFECTIVE DATE:_____ IS YOUR INSURANCE PLAN AN HMO? YES / NO

PRIMARY CARE PHYSICIAN _____ PHONE #_____

INSURED'S INFORMATION (IF OTHER THAN THE PATIENT)

NAME: _____

SSN#: _____DATE OF BIRTH:_____

SECONDARY INSURANCE

NAME AS APPEARS ON CARD:_____

INSURANCE COMPANY NAME & ADDRESS:_____

PHONE NUMBER:_____POLICY#:_____GROUP #:_____

EFFECTIVE DATE:_____IS YOUR INSURANCE PLAN AN HMO? YES / NO

PRIMARY CARE PHYSICIAN _____ PHONE #_____

INSURED'S INFORMATION (IF OTHER THAN THE PATIENT)

NAME: _____

SSN#: _____DATE OF BIRTH:_____

_____

******IS YOUR CONDITION DUE TO AN AUTO ACCIDENT YES / NO IF YES, WE WILL NEED THE FOLLOWING:

NAME OF AUTO INSURANCE: _____ POLICY #_____ DOA: _____

WORK RELATED ACCIDENT? YES / NO IF YES, WE WILL NEED THE FOLLOWING:

NAME OF EMPLOYER _____ PHONE #_____ DOI: _____

SARASOTA RETINA INSTITUTE

GENERAL HEALTH HISTORY FORM

PLEASE PRINT

NAME_____ M ☐ F ☐ **DATE OF BIRTH** _____ **DATE** _____ **CHART#**_____

FAMILY DOCTOR'S NAME _____ **OTHER PHYSICIANS** _____

Thank you for filling out the following information and Welcome To Our Practice

CARDIOVASCULAR	YES	NO
ARRYTHMIA	☐	☐
MURMUR/GALLOP___OTHER_____		
CORONARY ARTERY DISEASE	☐	☐
FLUID RETENTION	☐	☐
**HEART DISEASE*	☐	☐
CAD/ANGINA___CHF___OTHER____		
**HIGH BLOOD PRESSURE*	☐	☐

PULMONARY		
ASTHMA	☐	☐
BRONCHITIS	☐	☐
EMPHYSEMA	☐	☐

ENDOCRINE

GASTROINTESTINAL TRACT		
HERNIA	☐	☐
STOMACH PROBLEMS	☐	☐
ULCERS	☐	☐

SKELETAL		
AMPUTATION/LOST APPENDAGE_____	☐	☐
ARTHIRTIS TYPE _____	☐	☐
BROKEN BONES/JOINTS _____	☐	☐
GOUT	☐	☐
OSTEOPOROSIS	☐	☐

BLOOD		
ANEMIA TYPE _____	☐	☐
BLEEDING PROBLEMS	☐	☐
HIV	☐	☐
TEMPORAL ARTERITIS	☐	☐

NEUROLOGICAL		YES	NO
ALZHEIMERS		☐	☐
FACIAL PALSY	SIDE_____	☐	☐
HEADACHES		☐	☐
MIGRAINES		☐	☐
PARALYSIS	SIDE_____	☐	☐
PARKINSONISM		☐	☐
SEIZURES	TYPE_____	☐	☐
STROKE	SIDE_____	☐	☐

URINARY TRACT			
KIDNEY PROBLEMS	TYPE_____	☐	☐
PROSTATE PROBLEMS	TYPE_____	☐	☐
SHORTNESS OF BREATH		☐	☐

** DIABETES*	TYPE_____	☐	☐
THYROID	TYPE_____	☐	☐

OTHER			
BULGING EYES		☐	☐
HARD OF HEARING		☐	☐
HEPATITIS	TYPE _____	☐	☐
JAUNDICE		☐	☐
LIVER PROBLEMS		☐	☐
SHINGLES		☐	☐
SINUS		☐	☐
SKIN RASH		☐	☐
WEIGHT LOSS/GAIN (RECENT)		☐	☐
OTHER _____		☐	☐

CANCER	TYPE_____	☐	☐
	DATE DIAGNOSED _____	☐	☐
	TREATMENT _____	☐	☐

MEDICATION ALLERGIES

_____
_____
_____
_____
_____

ORAL MEDICATIONS/DOSAGE

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____

PREVIOUS GENERAL SURGERIES	YEAR
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

NAME: _____ DATE OF BIRTH _____ DATE _____ CHART# _____

OCULAR HEALTH HISTORY

1. What is your **primary complaint** about your eyes **TODAY**?_____

2. Other eye complaints_____

3. When and where was your last eye exam?_____

4. Have you ever been diagnosed for any of the following: (**please check**)

	YES	NO	EYE (Right / Left / Both)	YEAR
CATARACTS	☐	☐		
CROSSED EYES	☐	☐		
CORNEA PROBLEMS	☐	☐		
DIABETIC EYE DISEASE	☐	☐		
DOUBLE VISION	☐	☐		
EYE MUSCLE PROBLEM	☐	☐		
EYE TRAUMA	☐	☐		
GLAUCOMA	☐	☐		
LAZY EYE	☐	☐		
MACULAR DEGENERATION	☐	☐		
RETINAL DETACHMENT	☐	☐		
RETINAL TEAR	☐	☐		
OTHER (PLEASE LIST)				
_____			_____	_____
_____			_____	_____

4. List any eye surgery and / or laser eye surgeries that you have had:

EYE SURGERY	RIGHT	LEFT	PHYSICIAN / LOCATION	YEAR
_____	☐	☐	_____	_____
_____	☐	☐	_____	_____
_____	☐	☐	_____	_____
_____	☐	☐	_____	_____
_____	☐	☐	_____	_____

4. **EYE MEDICATIONS**

	RIGHT	LEFT	EYE MEDICATIONS	RIGHT	LEFT
_____	☐	☐	_____	☐	☐
_____	☐	☐	_____	☐	☐
_____	☐	☐	_____	☐	☐
_____	☐	☐	_____	☐	☐
_____	☐	☐	_____	☐	☐

SOCIAL HISTORY

Single ☐ Married ☐ Widowed ☐ Divorced ☐

Live Alone **YES** ☐ **NO** ☐

Occupation Past _____

Occupation present _____

Tobacco Use **YES** ☐ **NO** ☐ Packs/Day_____

Alcohol Use **YES** ☐ **NO** ☐ Drinks/Day_____

FAMILY HISTORY (AND WHOM)

Diabetes _____

Glaucoma _____

Macular Degeneration _____

Other Eye Problems_____

Father Living **YES** ☐ **NO** ☐

Mother **YES** ☐ **NO** ☐

SARASOTA RETINA INSTITUTE

HIPAA COMPLIANCE NOTIFICATION TO PATIENTS

To Our Valued Patients:
The misuse of protected health information has been identified as a national problem causing some patients inconvenience, aggravation and money. We want you to know that all of our employees/managers periodically receive training to assist them in understanding and complying with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with a particular emphasis on the "Privacy Rule". We strive to achieve the highest standards of ethics and integrity in performing services for our patients.

When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information. Other entities may have indirect treatment relationships with you (such as the physician reading your x-ray) and we may have to disclose personal health information for purposes of treatment or payment. These entities are most often not required to obtain patient consent.

You may refuse, in writing, the consent of disclosure of your personal health information. Under this law, we then have the right to refuse to treat you should you refuse to disclose your personal health information. At any time in the future, you may refuse all or part of disclosure of your personal health information. However, you may not revoke actions that have already been taken which relied on this or a previously signed consent.

It is our policy to determine appropriate uses of personal health information in accordance with the governmental rules, laws and regulations. We want to ensure that our office never contributes in any way to the growing problem of improper disclosure of personal health information. We have implemented a program we believe will help us prevent any inappropriate use of personal health information.

We also know that we are not perfect! Because of this fact, our policy is to listen to our patients and employees without any thought of penalty if they feel an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem, so we may remedy the situation promptly.

If you have any questions, please ask to speak to the Privacy Officer, Lois Delagrange.

Thank you for being one of our highly valued patients.

_____ _____

Signature of Patient or Authorized Patient Date